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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAURA LORRAINE MCKNIGHT a.k.a Laura M. Archer a.k.a. Laura Cheatham a.k.a. Laura McKnight Archer 154 Cortez Street Capitola, CA 95010 Registered Nurse License No. 600106 Respondent.	Case No. 2008-299 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 4, 2002, the Board of Registered Nursing issued Registered Nurse License Number 600106 to Laura Lorraine McKnight, also known as Laura M. Archer, also known as Laura Cheatham and also known as Laura McKnight Archer (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

5. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

6. Section 4326 of the Code states, in pertinent part:

"(a) Any person who obtains a hypodermic needle or hypodermic syringe by a false or fraudulent representation or design or by a forged or fictitious name, or contrary to, or in violation of, any of the provisions of this chapter, is guilty of a misdemeanor.

"(b) Any person who has obtained a hypodermic needle or hypodermic syringe from any person to whom a permit has been issued as provided in Article 9 . . . and who uses, or permits or causes, directly or indirectly, the hypodermic needle or hypodermic syringe to be used for any purpose other than that for which it was obtained is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not exceeding one thousand dollars ($1000), or by imprisonment in a county jail not exceeding one year, or both a fine and imprisonment."

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

8. "Vicodin" and "Vicodin ES" are Schedule III controlled substances pursuant to Health and Safety Code section 11056(e)(4) and dangerous drugs pursuant to Business and Professions Code section 4022 in that they can be lawfully dispensed only by prescription. Vicodin is a trade name for the narcotic substance hydrocodone or dihydrocodeinone with the non-narcotic substance acetaminophen. Each tablet of Vicodin contains 5 mg of hydrocodone bitartrate and 500 mg of acetaminophen. Vicodin is a semisynthetic narcotic analgesic (painkiller) similar to codeine, and may be used as a potentiator for central nervous system depressants.

9. "Cocaine" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(6) and a dangerous drug pursuant to Business and Professions Code section 4022.

10. "Ativan" is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(16) and a dangerous drug pursuant to Business and Professions

Code section 4022 in that it can be lawfully dispensed only by prescription. Ativan is a trade name for Lorazepam. It is a centrally-acting narcotic analgesic similar to codeine, and may be used as a potentiator for central nervous system depressants.

11. "Heroin" is a Schedule I controlled substance pursuant to Health and Safety Code section 11054(c)(11) and a dangerous drug pursuant to Business and Professions Code section 4022. It is chemically known as dicetylmorphine, originally manufactured as a substitute for morphine.

12. "Suboxone" is a brand name for Buprenorphine HCL and Naloxone HCL, a sublingual tablet, classified as an Opiate. Under the Drug Addiction Treatment Act of 2000 codified at 21 U.S.C. 823(g), prescription use of this product in the treatment of opioid dependance is limited to physicians who meet qualifying requirement. It is classified as a controlled substance under Schedule III of the Federal Controlled Substances Act and section 11058(d) of the Health and Safety Code and is a dangerous drug pursuant to Business and Professions Code section 4022. Buprenorphine is potent (30 to 50 times the analgesic potency of morphine) and has a long duration of action. Suboxone has the potential for abuse and produces dependence of the opioid type with a milder withdrawal syndrome than that of full agonists.

13. "Dilaudid" is a trade name for Hydromorphone and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(K) and a dangerous drug pursuant to Business and Professions Code section 4022.

14. "Sublimaze" is a brand name for Fentanyl, an opiate analgesic, and is a Schedule II controlled substance as defined by section 1308.12 of Title 21 of the Federal Code of Regulations and is a dangerous drug pursuant to Business and Professions Code section 4022. It is a strong opioid medication and is indicated in the treatment of chronic pain that cannot be managed by lesser means.

15. "Methadone" is a brand name for Dolophine Amidone and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(14) and a dangerous drug pursuant to Business and Professions Code section 4022.

16. "MS Contin" is the brand name for Morphine Sulfate (MS) and is a

Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1) and a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule II controlled substance as defined by section 1308.12(b)(1) of Title 21 of the Federal Code of Regulations. Morphine is a central nervous system (CNS) depressant, is a systemic narcotic and analgesic used in the management of pain.

17. "Midazolam HCI" is the generic name for Versed and is a Schedule IV controlled substance as defined by section 1308.12(b)(1) of Title 21 of the Federal Code of Regulations and is a dangerous drug pursuant to Business and Professions Code section 4022. It is a short-acting benzodiazepine CNS depressant and is indicated for preoperative sedation/anxiolysis/amnesia, or for inducation of general anesthesia.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

18. On or about September 30, 2003, respondent, after recently completing a residential treatment program at Janus in Santa Cruz County, was found by her children passed out at home with a tourniquet on her arm from an overdose of Heroin.

19. Respondent, by her own admission, regularly abused Heroin and Cocaine from June 2003 to September 2003, and regularly took syringes from Kaiser–Santa Clara, where she was employed as a registered nurse from approximately September 2002 to April 2003.

20. Respondent's conduct, as alleged in paragraphs 18 and 19, constitutes unprofessional conduct within the meaning of Code section 2762(b), and provides grounds for disciplinary action under Code section 2761(a), in that she used controlled substances and dangerous drugs to an extent and in a manner dangerous or injurious to herself or others.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

21. Paragraphs 18 and 19 are incorporated by reference as though fully set forth.

22. Respondent's conduct, as alleged in paragraphs 18 and 19, constitutes unprofessional conduct within the meaning of Code section 2762(a) (unlawful obtaining of

dangerous drugs or devices), and provides grounds for disciplinary action under Code section 2761(a) in that respondent unlawfully obtained and used hypodermic syringes, in violation of Code sections 4326 (a) and 4326 (b).

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

23. From September 2002, to April 2003, respondent worked for RN Network, where she was assigned to work at Kaiser-Santa Clara. From approximately January 2003 to approximately February 2003, respondent, by her own admission, diverted the wasted portion of pain medications (primarily Morphine) from medications that she had administered to her Kaiser-Santa Clara PICU patients. She took the wasted medications and the syringes to self-administer at home. By early March 2003, she was regularly diverting the wasted medications and syringes for self-use at home.

24. By mid-March 2003, respondent, by her own admission, began using her patient's wasted pain medications at the hospital. She performed her shifts while impaired. She would go into the bathroom and self-inject pain medication, primarily Morphine, into her hands and/or arms. She was regularly diverting and self-injecting the diverted medications to herself during her nursing shift.

25. On April 15, 2003, respondent, by her own admission, withdrew a tubex of Morphine 4mg. for a PICU patient who did not have a physician's order for Morphine and self-injected the Morphine into her arm or hand. On that occasion, respondent was observed to be staggering and to have slowed speech and movement and a flat affect.

26. Later, during the shift, respondent was asked by the nursing supervisor to go to her office where the supervisor told respondent that she appeared to be under the influence. Respondent was asked to accompany the supervisor to the Kaiser-Santa Clara Emergency Department for a urine sample which respondent provided.

27. On April 15, 2003, Celia Ryan R.N., the director of Quality Outcomes at Kaiser Permanente, filed a complaint with the Board of Registered Nursing, alleging that on April 15, 2003, respondent was staggering and had slowed speech while working at the Kaiser-

Santa Clara Pediatric Intensive Care Unit (PICU.)

28. Respondent, by her own admission, was terminated from RN Network and from Kaiser-Santa Clara. She stated that this termination was because of drug discrepancies found during her April 15, 2003 shift and because her April 15, 2003 drug test was positive for Morphine.

29. An audit of narcotic medication withdrawals on the hospital's computerized dispensing system (Pyxis) made by respondent, conducted for the time period beginning on July 1, 2002, to November 30, 2002, and January 2003, to April 15, 2003, revealed gross discrepancies and inconsistences in patient records and corresponding Pyxis records. The following are examples of incidents of gross narcotic discrepancies and inconsistencies revealed by the audit:

Patient 3-QB

a. On February 18, 2003 (time illegible), patient 3-QB's physician ordered Lorazepam 0.5 mg. per nasojejunal tube every four hours.

1. The PYXIS report shows that respondent withdrew one Lorazepam 2 mg./1ml. on February 18, 2003, at 7:50 p.m., gave to the patient Lorazepam 0.5 mg., and wasted 1.5 mg. with a witness identified as SEM. The Medication Administration Record (MAR) shows that respondent did not document the administration of the Lorazepam 0.5 mg. on the MAR until February 18, 2003, at 10:00 p.m.

2. The PYXIS report shows that respondent withdrew one Lorazepam 2 mg./1 ml. for the patient on February 19, 2003, at 2:02 a.m., but the MAR shows that respondent administered to the patient Lorazepam 0.5 mg. at 2:00 a.m. and at 6:00 a.m. One mg. Lorazepam remains unaccounted for.

3. The PYXIS report shows that on February 19, 2003, at 2:04 a.m., respondent accessed the PYXIS machine for Lorazepam 2 mg./1ml. There is an unintelligible entry/reason for opening the drawer seconds after respondent had previously opened the drawer and obtained Lorazepam for the patient.

b. On February 18, 2003, at 6:40 p.m., patient 3-QB's physician ordered

Morphine Sulfate 1 mg. IV every two hours for agitation. The PYXIS report shows that respondent withdrew one Morphine Sulfate 2 mg./1ml. on February 19, 2003, at 12:19 a.m. The MAR shows that respondent administered Morphine Sulfate 0.5 mg. to the patient on February 19, 2003, at 12:00 a.m. and at 3 a.m. One mg. Morphine Sulfate is unaccounted for.

Patient 2-DH

c. On April 14, 2003, at 11:03 a.m., patient 2-DH's physician ordered Morphine Sulfate 4 mg./1ml. for moderate pain. Theodore James Sloniker, R.N., was assigned to care for this patient, not respondent. On April 15, 2003, at 3:57 a.m., respondent withdrew one Morphine Sulfate syringe 4 mg./1ml. from the PEDI-PYXIS machine for this patient. On April 15, 2003, at 4:02 a.m., Sloniker witnessed respondent return to the PEDI-PYXIS machine a vial labeled PEDI-PYXIS machine for patient 2-DH. The vial was subsequently withdrawn from the PEDI-PYXIS machine and sent to a laboratory for analysis. The lab report showed that the concentration of Morphine contained in the vial was less than that posted on the label. Respondent admits that she withdrew Morphine from the vial, self-administered the Morphine, and then filled the vial with saline solution and returned the vial to the PEDI-PYXIS machine.

30. Respondent's conduct in failing to document or record the disposition of controlled substances, and in making other grossly inconsistent entries, as alleged in paragraph 29 above, constitutes unprofessional conduct within the meaning of Code section 2762(e) and provides grounds for disciplinary action under Code section 2761(a).

FOURTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

31. Paragraphs 23-28 are incorporated by reference as though fully set forth.

32. Respondent's conduct in obtaining and possessing in violation of the law, pain medications, primarily Morphine, and syringes, as alleged in paragraphs 23-28 above, constitutes unprofessional conduct within the meaning of Code section 2762(a) and provides grounds for disciplinary action under Code section 2761(a).

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FIFTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

33. Paragraphs 23-28 are incorporated by reference as though fully set forth.

34. Respondent's use of the pain medications, primarily Morphine, as alleged in paragraphs 23-28 above, to an extent and in a manner dangerous to herself and the public, specifically the hospital patients for whom she was responsible and to whom she was in close proximity, and to the extent that her use impaired her ability to conduct with safety to the public the practice authorized by her license, constitutes unprofessional conduct within the meaning of Code section 2762(b) and provides grounds for disciplinary action under Code section 2761(a).

SIXTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

35. From September 19, 2005, to May 31, 2007, respondent worked the 7:00 p.m. to 7:30 a.m. weekend night shifts as an RN at the Community Hospital of Los Gatos (CHLG) through Maxim Health Care Services, a nursing registry. She was placed on leave of absence following an investigation which disclosed controlled drug discrepancies involving Dilaudid and Fentanyl from November 11, 2006, to January 17, 2007. On February 7, 2007, respondent was removed from her nursing assignment due to drug discrepancies and was asked to take a urine drug test. The "Medtox" Laboratory report was inconclusive for Fentanyl "due to unknown interference." On February 20, 2007, during a meeting with supervisors at CHLG, respondent admitted that she had taken Fentanyl and Dilaudid from CHLG for her own use and she admitted to having tampered with, and taken, contents of controlled substances from patients' epidural bags for her own use. She submitted her letter of resignation to CHLG which was effective May 31, 2007.

36. An audit of narcotic medication withdrawals on Pyxis made by respondent, conducted for the time period beginning on November 11, 2006, to January 25, 2007, revealed gross discrepancies and inconsistences in patient records and corresponding Pyxis records. The following are examples of incidents of gross narcotic discrepancies and inconsistencies revealed by the audit:

Patient 1

a. On November 11, 2006, at unknown time, patient 1's physician ordered Dilaudid 1 mg. IV every two hours as needed for severe pain. That same day, at 8:00 p.m., respondent noted on the physician order sheet that the physician ordered Vicodin 5/500 p.o. (by mouth) every six hours as needed for pain. If not effective, then use IV Dilaudid as previously ordered.

1. At 7:59 p.m., respondent removed from PYXIS one Hydromorphine/Dilaudid 4mg./1 ml. syringe. The PYXIS report shows the access as an override. Respondent failed to list on the PYXIS report the reason for the override or to document the waste on the PYXIS report. Respondent failed to document the administration of Dilaudid (any dosage) on the November 11, 2006, and November 12, 2006 MARs for this removal from PYXIS, on the Outcome Notes, and on the Critical Care Flowsheet-Pain column. Respondent's notes in the Critical Care Flowsheet-Pain column are illegible.

2. On November 12, 2006, at 4:06 a.m., respondent removed from PYXIS one Hydromorphone/Dilaudid 4 mg./1 ml. syringe. The PYXIS report shows the access as an override. The PYXIS report shows that respondent administered Dilaudid 1 mg. and with a witness wasted Dilaudid 3 mg. Respondent did not chart administration of Hydromorphone/Dilaudid 1 mg./1 ml. on the Critical Care Flowsheet and Outcome Notes until 6:00 a.m. and on the MAR at 6:30 a.m. The patient's pain at 4:00 a.m. is listed as "restless" and at 6:00 a.m. as "facial grimace."

Patient 2

a. Patient 2's physician ordered Dilaudid 1 mg. IV every three hours for severe pain. On December 8, 2006, at 10:00 p.m., respondent noted on the Physician's Order sheet " Dilaudid to 2 mg. IV" every hour as needed for pain.

1. On December 10, 2006, at 3:52 a.m., respondent withdrew from PYXIS one Hydromorphone/Dilaudid 4 mg./1 ml. syringe. Respondent charted administration of Hydromorphone/Dilaudid 2 mg. at 3:45 a.m. but failed to waste and/or account for Hydromorphone/Dilaudid 2 mg.

2. On December 10, 2006, at 4:56 a.m., respondent withdrew from PYXIS one Hydromorphone/Dilaudid 4 mg./1 ml. syringe. Respondent documented on the MAR that she administered Hydromorphone/Dilaudid 2 mg. to Patient 2 at 5:00 a.m. but failed to waste and/or account for Hydromorphone/Dilaudid 2 mg.

Patient 3

a. On December 11, 2006, at 5:07 p.m., Patient 3's physician ordered Hydromorphone/Dilaudid 1 mg./5 ml. every hour as needed for pain. In addition, on December 11, 2006, at 5:07 p.m., Patient 3's physician ordered Midazolam HCL/Versed 0.5mg. as needed for anxiety.

1. On December 16, 2006, at 11:21 p.m., respondent signed out from PYXIS one Hydromorphone/Dilaudid 2 mg./1 ml. syringe. Respondent charted on the MAR that she administered Hydromorphone/Dilaudid 1 mg./5 ml. to the patient at 11:30 p.m. and 12:00 p.m. The Outcome Notes at 9:30 p.m. and 10:40 p.m. show that the patient denied discomfort and pain and that the patient was comfortable. At 12:00 p.m., respondent charted on the Outcome Notes that she administered "medication" to the patient at 11:30 p.m. for pain and anxiety. She failed to follow the physician's order which was to administer Dilaudid 1 mg. every hour for pain, not every half hour.

2. On December 16, 2006, at 11:21 p.m., respondent removed from PYXIS one Midazolam HCL/Versed 2 mg./2 ml. vial. Respondent charted administration of 0.5 mg. at 11:30 p.m. but failed to document on PYXIS or to otherwise account for the remaining dosage of Versed.

3. On December 17, 2006, at 12:57 a.m., respondent signed out from PYXIS one Hydromorphone/Dilaudid 2 mg./ 1 ml. syringe for Patient 3. Respondent charted administration of Hydromorphone/Dilaudid 1 mg. on Patient 3's MAR at 1:00 a.m. but failed to document on PYXIS or to otherwise account for the Dilaudid 1 mg.

4. On December 17, 2006, at 1:18 a.m., respondent signed out from PYXIS one Midazolam HCL/Versed 2 mg./2 ml. vial for Patient 3. Respondent failed to document on PYXIS or to otherwise account for the unused dosage of Versed.

5. On December 17, 2006, at 2:03 a.m., respondent signed out from PYXIS one Hydromorphone/Dilaudid 2 mg./1 ml. syringe. She documented on the MAR that she administered Hydromorphone/Dilaudid 1 mg. to the patient at 2:00 a.m. She documented on the Outcome Notes the administration of Dilaudid (dose not indicated) at 2:00 a.m. At 3:00 a.m., she noted that the patient verbalized no pain or distress. Respondent failed to document on PYXIS or to otherwise account for the remaining Dilaudid 1 mg.

6. On December 17, 2006, at 2:03 a.m., respondent signed out from PYXIS one Midazolam HCL/Versed 2 mg./2 ml. vial for Patient 3. Respondent failed to document on PYXIS or to otherwise account for the unused dosage of Versed.

7. On December 17, 2006, at 3:57 a.m., respondent signed out from PYXIS one Hydromorphone/Dilaudid 2 mg./1 ml. syringe. She documented on the MAR that she administered Hydromorphone/Dilaudid 1 mg. to the patient at 4:00 a.m. At 4:00 a.m., she noted on the Outcome Notes that she medicated the patient for "restlessness" and "apparent pain." Respondent failed to document on PYXIS or to otherwise account for the remaining Dilaudid 1 mg.

8. On December 17, 2006, at 6:30 a.m., respondent signed out from PYXIS one Midazolam HCL/Versed 2 mg./2 ml. vial for Patient 3. Respondent failed to document on PYXIS or to otherwise account for the unused dose of Versed.

Patient 4

a. On January 7, 2007, at 5:30 p.m., Patient 4's physician ordered Lorazepam/Ativan 1 mg. IV every four hours as needed for anxiety or agitation.

1. Respondent signed out from PYXIS Lorazepam/Ativan 2 mg. vial for Patient 4 on January 7, 2007 at 11:44 p.m. Respondent charted administration of Lorazepam/Ativan 1 mg. on the patient's MAR at 11:30 p.m., fourteen minutes before she signed out the Ativan. At 12:00 a.m., respondent charted on the patient's Outcome Flowsheet that she administered Ativan (dose not documented) to the patient at 11:30 p.m. The Critical Care Flowsheet-Riker assessment at 10:00 p.m. and 12:00 a.m. shows that the patient was calm and cooperative. Respondent failed to make any notations on the Critical Care Flowsheet at 11:00

p.m. Respondent failed to document or otherwise account for Ativan 1 mg.

2. Respondent signed out Lorazepam/Ativan 2 mg. vial for Patient 4 on January 8, 2007, at 3:50 a.m. She wrote the order on the MAR. She failed to document that date and time of the order. She charted administration of Ativan 1 mg. on Patient 4's MAR at 3:30, twenty minutes before she signed out the Ativan. At 4:00 a.m., respondent charted on the Outcome Flowsheet that the patient was calm and cooperative after receiving Ativan (dose not documented) at 3:30 a.m. The Critical Care Flowsheet-Riker assessment shows that the patient was calm and cooperative. Respondent failed to document or otherwise account for the Ativan 1 mg.

3. Respondent signed out from PYXIS Lorazepam/Ativan 2 mg. vial for Patient 4 on January 8, 2007, at 6:41 a.m. Respondent charted administration of Ativan 1 mg. on the patient's MAR at 7:00 a.m. The Critical Care Flowsheet-Riker assessment shows that the patient was calm and cooperative. At 7:00 a.m., respondent charted on Patient 4's Outcome Flowsheet that she gave the patient Ativan (dose not documented) for comfort and anxiety.

Patient 5

a. On January 10, 2007, Patient 5's physician ordered Dilaudid 0.5 mg. every thirty minutes as needed for pain.

1. On January 11, 2007, at 7:37 p.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. IV for Patient 5. She charted administration of Dilaudid 0.5 mg. on the patient's MAR at 8:00 p.m. and at 9:00 p.m. Respondent failed to document or otherwise account for the remaining dose of Dilaudid. She charted on the Critical Care Flow Sheet-Pain and Riker assessment sections that the patient was sedated. At 8:00 p.m., respondent documented on the Outcome Notes that the patient was medicated to keep the patient comfortable.

2. On January 11, 2007, at 11:36 p.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. for Patent 5. She charted administration of Dilaudid 0.5 on Patient 5's MAR at 11:00 p.m., which was prior to the time respondent signed out for the Dilaudid. Respondent failed to chart or otherwise account for the remaining dose of

Dilaudid. She charted on the Critical Care Flow Sheet-Pain and Riker assessment sections that the patient was sedated. At 11:00 p.m., respondent charted on the Outcome Notes that she administered Dilaudid (dose not charted) to the patient for pain. At 11:30 p.m., respondent documented on the same notes that the patient was in no apparent pain or distress.

3. On January 12, 2007, at 1:25 a.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. for Patient 5. She charted administration of Dilaudid 0.5 mg on the patient's MAR at 1:15 a.m., which was prior to the time she signed out for Dilaudid. At 2:00 a.m., respondent charted that the patient was medicated with Dilaudid. At 1:15 a.m., respondent charted on the Critical Care Flow Sheet that she administered to the patient Dilaudid (dose not documented.) The Pain and Riker assessment sections show that the patient was sedated. Respondent failed to chart or to otherwise account for the remaining dose of Dilaudid.

4. On January 12, 2007, at 3:32 a.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. for Patient 5. She charted administration for Dilaudid 0.5 mg. on Patient 5's MAR at 3:45 a.m. At 3:45 a.m., respondent charted on the Critical Care Flow Sheet that she administered to the patient Dilaudid (dose not documented.) The Pain and Riker assessment sections show that the patient was sedated. Respondent failed to chart or otherwise account for the remaining dose of Dilaudid.

5. On January 12, 2007, at 5:53 a.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. for Patient 5. She charted administration of Dilaudid 0.5 mg. on Patient 5's MAR at 5:30 a.m., which was prior to the time respondent signed out for Dilaudid. At 5:30 a.m., respondent charted on the Critical Care Flow Sheet that she administered to the patient Dilaudid (dose not documented.) The Pain and Riker assessment sections show that the patient was sedated. At 6:00 a.m., respondent documented that she medicated the patient with Dilaudid at 5:30 a.m. Respondent failed to chart or otherwise account for the remaining dose of Dilaudid.

6. On January 12, 2007, at 7:25 a.m., respondent signed out from PYXIS Hydromorphone HCL/Dilaudid 2 mg./1 ml. for Patient 5. At 7:15 a.m., she charted on

the Critical Care Flow Sheet that she administered to the patient Dilaudid (dose not documented.) The Pain and Riker assessment sections show that the patient was sedated. Respondent failed to chart the Dilaudid on Patient 5's MAR. Repondent failed to chart or otherwise account for the remaining dose of Dilaudid.

Patient 6

a. On January 12, 2007, at 1:05 a.m., Patient 6's physician ordered Morphine Sulfate 1 mg. every three hours as needed for pain. The order was discontinued on January 13, 2007, at 12:45 p.m.

1. On January 13. 2007, at 4:19 p.m., respondent signed out from PYXIS one Morphine Sulfate 1 mg./2 ml. syringe. At 4:15 a.m., respondent charted on the patient's MAR that she administered Morphine Sulfate 1 mg. IV. At 4:15 a.m., respondent noted on the Critical Care Flow Sheet that Morphine (dose not documented) was administered to the patient. The Critical Care Flow Sheet-Pain Assessment section at 4:00 a.m. shows pain as "6/10" and at 4:20 a.m. the section is blank. The Riker section shows that the patient was sedated. At 5:00 a.m., respondent documented on the Outcome Notes that she administered "Morphine x1" OC 5:00 a.m. Respondent failed to chart or otherwise account for the remaining Morphine 1 mg.

Patient 7

a. On January 16, 2007, at 7:47 p.m., Patient 7's physician ordered Fentanyl Citrate 0.75 mg./1.5 ml. IV every thirty minutes as needed for pain. This order was noted by the nursing staff (illegible name) at 8:05 p.m.

1. On January 16, 2007, at 11:34 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 11:30 p.m., respondent charted on the patient's MAR that she administered Fentanyl 75 mg. IV. At 12:00 a.m., respondent noted on the Critical Care Flow Sheet-Events Column that she administered to the patient Fentanyl (dose not documented.) Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. At 12:00 a.m., respondent charted on the Outcome Notes that she received Patient 7 in the ICU/CCU), which was after she withdrew the Fentanyl from PYXIS. Respondent failed to chart or otherwise account for the remaining Fentanyl.

2. On January 17, 2007, at 12:23 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 12:15 a.m., respondent charted on the patient's MAR that she administered Fentanyl 75 mg. IV to Patient 7 at 12:15 a.m. She noted on the Critical Care Flow Sheet-Events Column that she administered to the patient Fentanyl (dose not documented.) Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form and on the Outcome Notes. Respondent failed to chart or otherwise account for the remaining Fentanyl.

3. On January 17, 2007, at 1:31 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 1:30 a.m., respondent charted on the patient's MAR that she administered Fentanyl 75 mg. IV. At 1:30 a.m., she documented that she administered to the patient Fentanyl (dose not charted.) Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form and on the Outcome Notes. Respondent failed to chart or otherwise account for the remaining Fentanyl.

4. On January 17, 2007, at 2:15 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 2:00 a.m., respondent charted on the patient's MAR that she administered Fentanyl 75 mg. IV. Respondent charted on the Critical Care Flow Sheet-Events Column that she administered "Fent" (dose not documented) at "02." At 2:00 a.m., she noted in the Outcome Notes that she continued to medicate frequently to "maintain patient in a calm state." Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. Respondent failed to chart or otherwise account for the remaining Fentanyl.

5. On January 17, 2007, at 2:43 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 2:30 a.m., prior to the removal of Fentanyl from PYXIS, respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent charted on the Critical Care Flow Sheet-Events Column that she administered "Fent" at 2:30 a.m. Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. Respondent failed to chart or otherwise account for the remaining Fentanyl.

6. On January 17, 2007, at 3:21 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 3:00 a.m., prior to the removal of Fentanyl from PYXIS, respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent charted on the Critical Care Flow Sheet-Events Column that she administered "Fent" at "03". Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. Respondent failed to chart or otherwise account for the remaining Fentanyl.

7. On January 17, 2007, at 3:42 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 3:30 a.m., prior to the removal of Fentanyl from PYXIS, respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent charted on the Critical Care Flow Sheet-Events Column that she administered "Fent" at 3:30 a.m. Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. Respondent failed to chart or otherwise account for the remaining Fentanyl.

8. On January 17, 2007, at 4:36 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. Respondent failed to complete the MAR for this PYXIS removal. At 4:00 a.m., respondent wrote on the patient's Outcome Notes to "see flow sheet." Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form. Respondent failed to chart or otherwise account for the remaining Fentanyl.

9. On January 17, 2007, at 6:06 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 6:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent noted on the Outcome Notes "no apparent distress." Respondent failed to complete charting on the Critical Care Flow Sheet Pain and Riker assessment form for PYXIS removal. Respondent failed to chart or otherwise account for the remaining Fentanyl.

10. On January 17, 2007, at 9:20 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 9:00 p.m., prior to the removal of Fentanyl

from PYXIS, respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent documented on the Critical Care Flow Sheet-Events Column that she administered "Fent" at 9:30 p.m. On the same form, she charted that the patient was very sedated. At 10:00 p.m., she charted on the Outcome Notes that the patient was non-responsive to verbal or tactile stimuli. On the same notes, she listed pain and discomfort as the second highest priority in treating this patient. Respondent wrote on the Outcome Notes that she medicated the patient with Fentanyl and Versed (doses not documented) approximately every two hours for "potential pain." Respondent failed to chart or otherwise account for the remaining Fentanyl.

11. On January 18, 2007, at 1:15 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 1:15 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent documented on the Critical Care Flow Sheet that the patient was very sedated and that she administered "Fent" (dose not charted) at 1:15 a.m. Respondent failed to make any entries during this hour on the Outcome Notes and she failed to chart or otherwise account for the remaining Fentanyl.

12. On January 18, 2007, at 3:19 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 3:30 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to complete any charting on the Critical Care Flow Sheet-Events, Pain and Riker assessments for this PYXIS removal. Respondent failed to chart or otherwise account for the remaining Fentanyl.

13. On January 18, 2007, at 5:33 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 5:30 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to make any entries during this hour on the Outcome Notes and failed to chart or otherwise account for the remaining Fentanyl.

14. On January 18, 2007, at 8:18 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 8:00 p.m., respondent charted on the

patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to make any entries during this hour on the Outcome Notes and failed to chart or otherwise account for the remaining Fentanyl.

15. On January 18, 2007, at 9:52 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 9:00 p.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

16. On January 19, 2007, at 12:24 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 12:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

17. On January 19, 2007, at 2:07 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 2:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV.

18. On January 19, 2007, at 4:32 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 4:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

19. On January 19, 2007, at 6:31 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 6:30 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

20. On January 19, 2007, at 9:32 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 9:30 p.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

21. On January 19, 2007, at 10:37 p.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 10:30 p.m., respondent charted on the

patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

22. On January 19 2007, at 11:52 p.m. respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 12:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

23. On January 20, 2007, at 1:53 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 2:00 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

24. On January 20, 2007, at 3:23 a.m., respondent signed out from PYXIS one Fentanyl Citrate 100 mcg./2 ml. amp. At 4:30 a.m., respondent charted on the patient's MAR that she administered to the patient Fentanyl 75 mg. IV. Respondent failed to chart or otherwise account for the remaining Fentanyl.

Patient 8

a. On January 16, 2007, at 11:00 p.m., Patient 8's physician ordered Dilaudid 20 mcg./ml. epidural infusion, Morphine Sulfate 2 mg. IV every thirty minutes for breakthrough pain, and Hydromorphone/Dilaudid 1 mg./5 ml. IV every thirty minutes as needed for breakthrough pain "despite Morphine."

1. Although respondent worked the January 16, 2007 (7:00 p.m.) to January 17, 2007 (7:30 a.m.) shift, she was not assigned to care for Patient 8. The patient was receiving Dilaudid via epidural drip. On January 17, 2007, at 4:41 a.m., respondent signed out from PYXIS for Patient 8 Dilaudid 4 mg. 1 ml. syringe via an override. She failed to chart on PYXIS any waste of this drug. Respondent failed to chart on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS.

2. Although respondent worked the January 17, 2007 (7:00 a.m.) to January 18, 2007 (7:30 a.m.) shift, she was not assigned to care for Patient 8. Patient 8 was receiving Dilaudid via epidural drip. On January 18, 2007 at 1:01 a.m., respondent signed out

from PYXIS for Patient 8 Dilaudid 4 mg. 1 ml. syringe via an override. She failed to chart on PYXIS any waste of this drug. Respondent failed to chart on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS.

b. On January 18, 2007, at 4:30 p.m., Patient 8's physician ordered Lorazepam 1 mg. IV every six hours.

1. Respondent was assigned to care for Patient 8 during the January 21, 2007 (7:00 p.m.) to January 22, 2007 (7:30 a.m.) shift. On January 22, 2007, at 3:14 a.m., respondent signed out from PYXIS for patient 8, one Lorazepam 2 mg./1ml. vial. At 6:00 a.m., respondent charted on the patient's MAR that she administered to the patient Lorazepam 1 mg. Respondent failed to chart on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS.

2. Respondent was assigned to care for Patient 8 during the January 28, 2007 (7:30 a.m.), to January 29, 2007 (7:00 p.m.) shift. On January 29, 2007, at 12:38 a.m., respondent signed out from PYXIS for patient 8, one Lorazepam 2 mg./1ml. vial. On January 28, 2007, at 12:00 a.m., respondent charted on the patient's MAR that she administered to the patient Lorazepam 1 mg. and on January 29, 2007, at 6:00 a.m., she charted on the patient's MAR that she administered to the patient Lorazepam 1 mg. Respondent failed to waste Lorazepam 1 mg. within a half hour of removing the drug from PYXIS. She administered the second dosage of Lorazepam 1 mg. hours after she initially withdrew the drug from PYXIS at 12:38 a.m. Respondent failed to chart the effect of this medication.

Patient 9

a. On January 15, 2007, at 10:00 a.m., Patient 9's physician ordered Hydromorphine/Dilaudid 20 mcg./1 ml. via continuous epidural infusion at 4 ml./hour. On January 16, 2007, at 1:30 a.m., the physician increased the Dilaudid epidural rate to the maximum dose of 12 ml./hour to increase the rate 8 ml./hour. The physician ordered Dilaudid 0.25 mg. IV PRN as needed every thirty minutes for breakthrough pain on January 15, 2007, at 10:00 a.m. On January 16, 2007, at 1:30 a.m., the physician changed the order to Dilaudid 0.4 mg. IV PRN as needed every thirty minutes for breakthrough pain. Respondent was not assigned

to care for Patient 9.

b. On January 17, 2007, at 6:00 a.m., the assigned nurse charted that the patient was sedated and that the patient was not experiencing any pain. On January 17, 2007, at 6:49 a.m., respondent signed out from PYXIS Dilaudid 4 mg. 1 mg. syringe via an override for Patient 9. Respondent failed to chart on PYXIS any waste of this drug. Respondent failed to chart on the MAR or to otherwise account for the removal of this controlled substance from PYXIS.

Patient 11

a. On January 14, 2007, at 1:05 p.m., Patient 11's physician ordered Morphine Sulfate 2 mg. every hour as needed for pain. Respondent was not assigned to care for patient 11. On January 17, 2007, at 2:59 a.m., respondent signed out from PYXIS one Morphine Sulfate 2 mg./ 1ml. syringe. Respondent failed to chart the administration of the controlled substances on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS. The January 16, 2007, to January 18, 2007 Critical Care Flow Sheets, which were completed by other nurses, show the patient's pain scale to be zero.

b. On January 13, 2007, at 1:05 p.m., Patient 11's physician ordered IV Versed 1 mg. every hour as needed for anxiety; 2 mg. every hour for anxiety not relieved by 1 mg; and 4 mg. every hour as needed for anxiety not relieved by 2 mg. Respondent was not assigned to care for patient 11.

1. On January 17, 2007, at 3:00 a.m., respondent signed out from PYXIS one Midaxolam HCL/Versed 5 mg./1 ml. vial. Respondent failed to chart the administration of the controlled substance on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS.

2. On January 17, 2007, at 11:45 p.m., respondent signed out from PYXIS one Midaxolam HCL/Versed 5 mg./1 ml. vial. Respondent failed to chart the administration of the controlled substance on the patient's MAR or to otherwise account for the removal of this controlled substance from PYXIS.

c. On January 22, 2007, at 11:00 a.m., patient 11's physician ordered

Diazepam/Valium 15 mg. (3 tablets) every six hours. Respondent was assigned to care for Patient 11 from January 24, 2007, to January 25, 2007 from 7:00 p.m. to 7:30 a.m. On January 25, 2007, at 12:14 a.m., respondent signed out from PYXIS for this patient three Diazepam 5 mg. tablets. The pre-printed MAR is stamped 6:00 p.m. and 12:00 a.m. At the 6:00 p.m. entry, respondent wrote on the MAR "removed from PYXIS." At the 12:00 a.m. entry, respondent wrote "NG." Respondent failed to complete legible documentation for the removal of this drug from PYXIS. There is no waste listed on the PYXIS report and respondent failed to otherwise account for the removal of this controlled substance from PYXIS.

Patient 12

a. On November 18, 2006, at 8:02 p.m., respondent withdrew from PYXIS one Lorazepam/Ativan 2 mg./1 ml./vial. This is an unintelligible entry. Respondent failed to chart onto PYXIS records the patient's name or any other identifying information to account for the removal of this controlled substance from PYXIS.

37. Respondent's conduct in failing to document or record the disposition of controlled substances, and in making other grossly inconsistent entries, as alleged in paragraph 36 above, constitutes unprofessional conduct within the meaning of Code section 2762(e) and provides grounds for disciplinary action under Code section 2761(a).

NINTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

38. Paragraphs 35-36 are incorporated by reference as though fully set forth.

39. Respondent's conduct in obtaining and possessing in violation of the law, pain medications, controlled substances, and dangerous drugs, and syringes, as alleged in paragraphs 35-36 above, constitutes unprofessional conduct within the meaning of Code section 2762(a) and provides grounds for disciplinary action under Code section 2761(a).

TENTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

40. Paragraphs 35-36 are incorporated by reference as though fully set

forth.

41. Respondent's use of the pain medications, controlled substances, and dangerous drugs, as alleged in paragraph 35 above, to an extent and in a manner dangerous to herself and the public, specifically the hospital patients whom she was responsible and to whom she was in close proximity, and to the extent that her use impaired her ability to conduct with safety to the public the practice authorized by her license, constitutes unprofessional conduct within the meaning of Code section 2762(b) and provides grounds for disciplinary action under Code section 2761(a).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 600106, issued to Laura Lorraine McKnight, also known as Laura McKnight Archer;

2. Ordering Laura Lorraine McKnight to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/23/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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